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Microinsurance in Pakistan: Progress, Problems, and Prospects

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Abstract

Microinsurance in Pakistan is still in its nascent stages. More than half of the current microinsurance policies in effect in Pakistan are offered through the Benazir Income Support Program (BISP), with the remainder provided in conjunction with microcredit services offered by various microfinance institutions (MFIs), microfinance banks, nongovernment organizations, and rural support programs (RSPs). The policies offered by the microcredit sector are mainly credit-life policies, which cover loan balances in the event of the borrower's death. In addition, some lenders—principally the RSPs—offer small health insurance policies covering the hospitalization of the borrower and (sometimes) their spouse. As catastrophic health expenses and deaths in the family are among the most important economic stressors that households face, it makes sense that microinsurance should first make inroads in these areas.

It is difficult to say what impact microinsurance has had in Pakistan, since few rigorous evaluations have been undertaken to date. What we do know is that utilization has been low, explained by providers as limited client awareness of the benefits and coverage. In the short to medium term, microinsurance outreach can be expanded by offering health microinsurance (HMI) coverage to microcredit borrowers' entire households, and by offering HMI to all community members within an RSP, rather than only microloan borrowers and their spouses. Partnering with mobile phone operators for automated, digital payments can also significantly expand potential customer volume while reducing transaction costs. HMIs might also be combined with health savings accounts that households can use to pay for medications and outpatient services not covered by HMI plans. Provinces could also leverage the existing database of poverty scorecards implemented by BISP to channel partially government-subsidized microinsurance policies toward poor households just above the BISP threshold.

Keywords: Microinsurance, social insurance, poor, Pakistan.

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1. Introduction: Defining Microinsurance

Broadly speaking, microinsurance is insurance for the poor. When it comes to defining the term more specifically or categorizing specific products such as "microinsurance", there is some lack of consensus. According to Churchill and McCord (2012), microinsurance can typically be characterized by: (i) the target group served (the poor, or more generally, those underserved by traditional insurance products); (ii) caps on the amount of coverage and premiums (low compared to traditional insurance products); (iii) the type of provider (such as "self-help groups" and other community-based organizations); and (iv) the distribution channel (including nongovernment organizations [NGOs], microfinance institutions [MFIs], and others). In addition, microinsurance often caters to the specific types of risk faced by the poor. It is often also characterized as being simpler to administer than traditional insurance.

2. Trends in Microinsurance Coverage

An estimated 500 million individuals are covered by microinsurance worldwide, 60 percent of who are in India (Churchill & McCord, 2012). In India, a combination of state-sponsored health insurance coverage and government mandates to the insurance sector to expand coverage to underserved segments of the population have been principally responsible for its large and rapidly growing share of the global microinsurance market. Over a period of just five years, India's RSBY program alone has enrolled 110 million individuals (Fan, 2013).

The microinsurance market in Pakistan has remained small. We estimate the number of policies in Pakistan to be nearly 7.4 million (see Table 1).[1] This is likely an underestimate, since data are unavailable (or not included) on a number of ongoing pilots, small life insurance policies through the Pakistan Post, and some new programs such as life/disability microinsurance and mobile phone microinsurance schemes including Zong and Telenor. On the other hand, it is estimated that at least 300 million people are covered by microinsurance in India.

[1] Note that this is the number of policies and not the number of people insured, since some individuals have both life and health insurance.

Table 1: Microinsurance policies in Pakistan: December 2012/January 2013

Province	Microcredit-linked microinsurance (credit life and health)	BISP life	BISP health	Naya Jeevan (approx.)	Other private HMI	Total
Punjab	2,172,808	1,355,785	319,911	3,000		3,848,504
Sindh	555,860	1,617,879		19,400		2,193,139
KP	53,445	862,278		1,000		915,723
Balochistan	6,937	208,966				215,903
AJK	46,087	68,818				114,905
Gilgit-Baltistan	10,135	24,424			32,832	67,391
Unknown						
Total	**2,854,194**	**4,138,150**	**319,911**	**23,400**		**7,368,087**

AJK = Azad Jammu and Kashmir, BISP = Benazir Income Support Program, HMI = health microinsurance, KP = Khyber Pakhtunkhwa.
Sources: MicroWatch, BISP, New Jubilee, interview with Naya Jeevan.

According to the Securities and Exchange Commission of Pakistan (SECP), the penetration of all insurance (not just microinsurance) was only 0.7 percent of GDP in 2010. The World Bank reports that 1.9 percent of Pakistanis have some form of insurance coverage (Nenova, Niang, & Ahmad, 2009). Within South Asia, insurance penetration in India is the highest at 5.1 percent of GDP, followed by Sri Lanka at 1.4 percent, and Bangladesh at 0.9 percent (Swiss Re, 2010). Data for 2010 from the Organisation for Economic Co-operation and Development (2012) indicates 9 percent penetration among its member countries. Until recently, the vast majority of microinsurance policies held in Pakistan were offered in conjunction with microcredit.

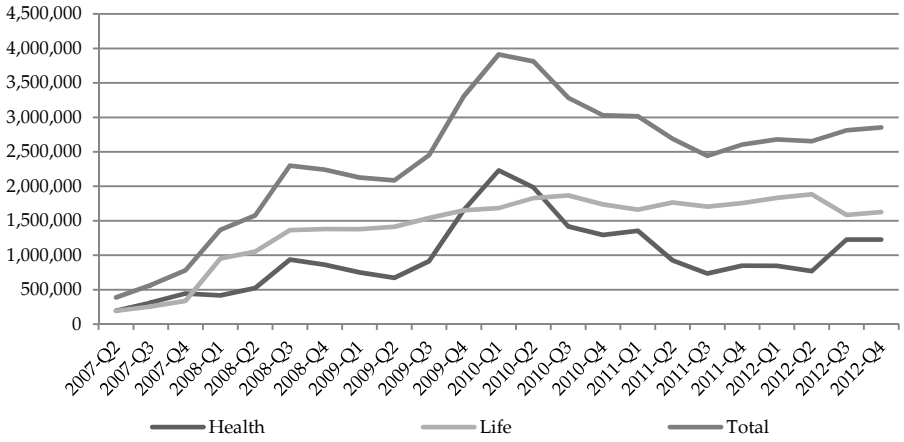
Credit life microinsurance has been available in Pakistan since around 2001[2] and has expanded rapidly in the last five years. Starting with 387,900 policies in 2007 (the earliest statistic available), 1.2 million and 1.6 million individuals were covered as of December 2012 by credit life and health insurance policies, respectively, offered through the microfinance sector (Pakistan Microfinance Network, 2007, 2012). In 2012, 42 percent of these policies were offered through rural support programs (RSPs), with the remainder offered by other microfinance providers. Most microcredit

[2] Interview with Maham Tarar (Kashf Foundation): Kashf has been offering credit life insurance since around 2001.

providers offer some form of microinsurance; as of 2011, out of 16 organizations, 11 provided credit life policies and 7 had health microinsurance (HMI) schemes (Pakistan Microfinance Network, 2011).

As Figure 1 shows, life insurance (specifically credit life) has been trending upward. The number of health insurance policies spiked widely and then peaked in the first quarter of 2010. This coincided with the initiation of the First Microinsurance Agency's (FMiA) health insurance schemes and the National Rural Support Programme's (NRSP) short-lived policy change (in Q4 2009, which was reversed by Q3 2010) under which their health policy covered all household members rather than just borrower and spouse.

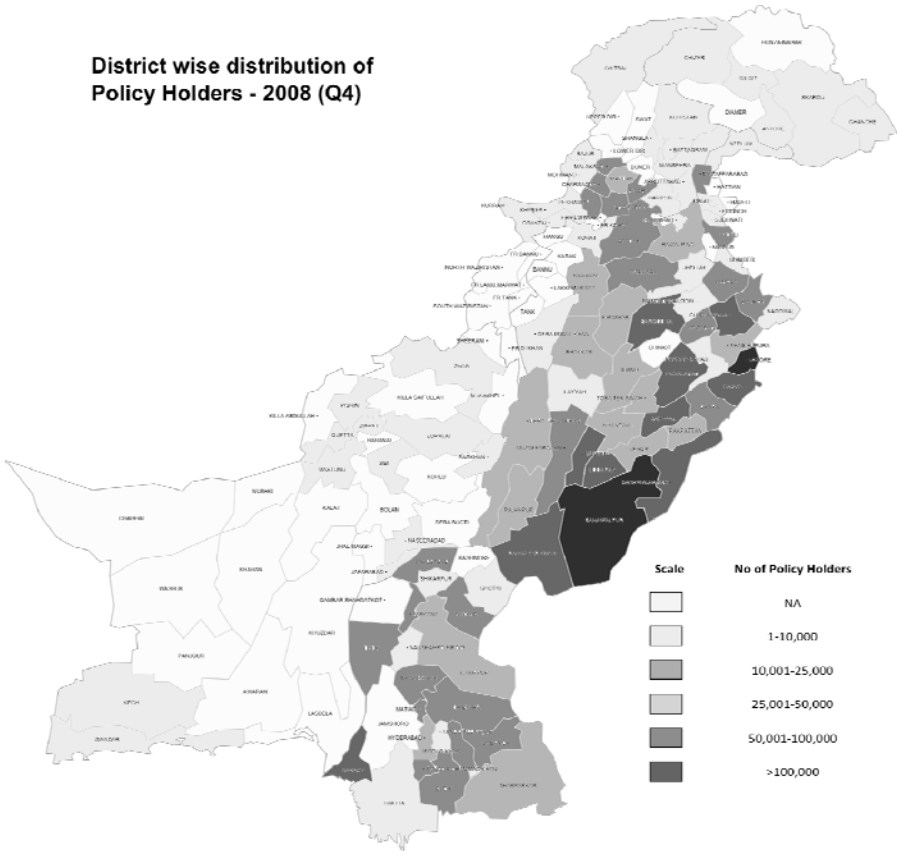
Figure 1: Microinsurance outreach through the microfinance sector: Number of policyholders



Microinsurance outreach in Pakistan was initially low and mainly concentrated in the rural areas, since the bulk of the providers were RSPs, which primarily operate in rural areas. Over time, the rural–urban balance has improved with the increased participation of MFIs in the microinsurance sector. Since 2008, the distribution of microinsurance in terms of the number of policyholders has become more concentrated in Punjab and Sindh (see Figure 2). Some parts of the Northern Areas also have access to microinsurance, but the numbers are quite low, ranging between 1,000 and 10,000 policyholders.[3]

[3] The data to which the maps refer have been collected by the Pakistan Microfinance Network in various editions of their newsletter, MicroWatch. According to Malik Khoja of Jubilee Life, the number of people insured in the Northern Areas has exceeded 10,000 since 2008.

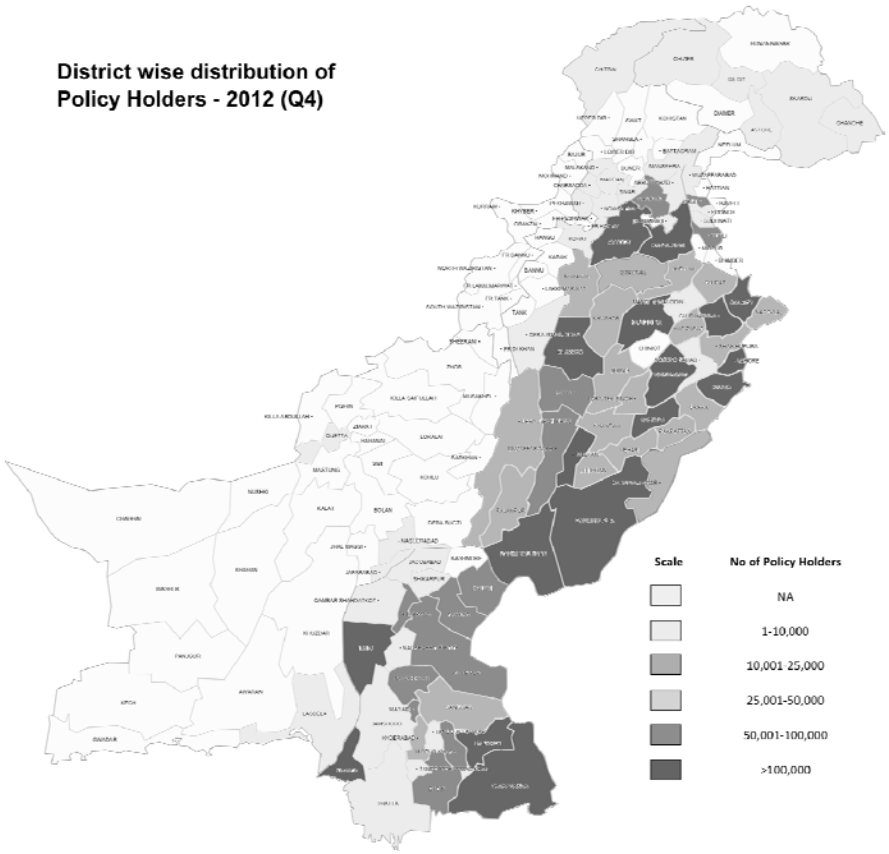
Figure 2: Microinsurance policies through the microfinance sector, Q4 2008



Source: Map constructed using data from MicroWatch, issue 10.

A somewhat disconcerting trend in district-wise outreach over the four-year period 2008–12 is that the geographical spread of microinsurance has been shrinking (see Figure 3). In 2008, microinsurance was spread across at least some districts in Balochistan, but by 2012 there were few microfinance operations outside Quetta. Within Punjab, there has been considerable progress in expanding the number of policyholders in the larger, more affluent districts such as Lahore, Gujranwala, Rawalpindi, Faisalabad, Sargodha, and Multan, increasing their number to above 100,000. At the same time, microinsurance penetration and outreach have declined drastically in other districts such as Bahawalpur.

Figure 3: Microinsurance policies through the microfinance sector, Q4 2012



Source: Map constructed using data from MicroWatch, issue 26.

3. Sources of Risk and Demand for Microinsurance in Pakistan

The Pakistan Safety Net Survey reports that the largest shocks facing families are death, disability, or serious illness in the family; two thirds of respondents had experienced at least one shock in the previous three years (World Bank, 2007). The Benazir Income Support Program (BISP) has, accordingly, included life and health insurance as two key components of its program.

These risks are important for all poor and vulnerable households, not just the ultra-poor. A focus group of microcredit clients from the Kashf Foundation and NRSP ranked death and serious illness in the family as the two most stressful shocks (McGuinness & Tounytsky, 2006).

According to focus group discussions[4] carried out for the SECP's (2012) recent diagnostic report on microinsurance, the costs related to illness are the greatest event-related burden that many households face, with the expenses exceeding those of marriage, death, and childbirth. The burden of health-related expenses was reported to be significantly higher in rural areas due to the transportation costs associated with fewer hospital facilities in many areas. In all areas, focus group participants ranked health insurance as their top insurance priority, followed by life, agriculture, and business failure insurance. In rural areas, natural disaster insurance was second only to health.

4. Microinsurance and the Potential for Poverty Alleviation

Without formal insurance, the poor deal with risks and shocks (whether realized or potential) by way of the limited, mainly informal, options available to them. These include the build-up and use of precautionary savings; gifts given to and received from friends, neighbors, and/or relations; the sale of assets, including jewelry and land; income diversification strategies; and risk-mitigating production decisions such as planting drought- or pest-resistant crop varieties instead of high-yield ones or growing food over cash crops (Dercon & Kirchberger, 2008).

According to the Pakistan Safety Net Survey, the poor and ultra-poor often engage in harmful behaviors when faced with economic shocks: they may reduce food consumption, or take their children out of school and/or send them out to work (World Bank, 2007). McGuinness and Tounytsky (2006) show that a focus group of microcredit customers reported using savings, informal loans (from friends, family, or moneylenders), or MFI loans; decreasing household consumption; working extra hours; or selling assets to deal with shocks such as family deaths and serious illness. Many of the same coping strategies were cited by focus group discussions conducted by the SECP (2012) for its diagnostic study of microinsurance in Pakistan.

The literature reviewed by Dercon and Kirchberger (2008) hypothesizes that microinsurance can serve as a poverty alleviation device in three ways. First, it helps households deal with emergencies in such a way that they are not forced to sell off productive assets and are kept from falling into deeper poverty, particularly when informal insurance

[4] The focus groups discussions took place in urban (Lahore, Karachi), semi-urban (Rawalpindi, Hyderabad), and rural (Mianwali, Hyderabad, and Nawabshah) areas of Punjab and Sindh.

mechanisms are incomplete.[5] Second, microinsurance allows households to make investments that might help get them out of poverty – investments they may be otherwise hesitant to undertake because of the higher risk involved in higher-return projects. Evidence for the relationship between risk and agricultural production decisions can be found for Pakistan in Kurosaki and Fafchamps (2002) and for India in Mobarak and Rosenzweig (2012). Finally, insurance provides households the peace of mind needed to reduce their precautionary savings, increasing not only investment but also current consumption (of food, health, and education, for example).

5. Informal Insurance Arrangements

Even when consumption smoothing does take place in villages among neighbors and relatives, risk-sharing arrangements that are localized can only help with idiosyncratic or household-level events; aggregate shocks at the village level cannot be mediated in this way. On the other hand, consumption smoothing can also occur within kinship networks that extend beyond village boundaries, as documented in India (Mobarak & Rosenzweig, 2012). Nonetheless, microinsurance can potentially improve risk sharing when the insured pool expands beyond the limitations of informal networks as long as the transaction costs are not too high.

Research on informal insurance in Pakistan is based for the most part on a three-year panel dataset spanning four rural districts in the late 1980s, collected by the International Food Policy Research Institute (IFPRI). Using a variety of methods, these studies have tested for the presence of informal insurance mechanisms and correlates of insurance and risk aversion. In most, but not all, cases, the model of full insurance is rejected. Informal insurance is less likely to be observed where incomes are correlated and, surprisingly, where risk aversion is higher (Dubois, 2005). Transaction costs can reduce the level of informal insurance (Murgai, Winters, Sadoulet, & de Janvry, 2002) while financial intermediaries may enhance commitment to informal insurance arrangements (Foster & Rosenzweig, 1996). The literature documents risk-mitigating strategies such as precautionary savings (Alderman, 1996) and shifting planting away from cash crops (Kurosaki & Fafchamps, 2002), in addition to loss-coping strategies such as reducing consumption and selling assets (Alderman, 1996).

[5] Incomplete consumption smoothing has been documented in several studies, including Townsend (1994) for India and Fafchamps and Lund (2001) for the Philippines. Newer research on (in)complete informal insurance has moved away from tests for consumption smoothing, since the lack thereof might not simply capture the depth of risk sharing but could also reflect heterogeneous risk preferences within the community.

Alderman and Garcia (1993) and Dubois (2005) use the IFPRI dataset to test for full informal insurance. They reject the model of full insurance since individual consumption co-varies with respect to individual income (instead of village-level consumption), and the impact of individual household income is greater (rather than smaller) when village-level variables are included. Dubois also tests for informal insurance at the village level, this time allowing for heterogeneous risk preferences. The study rejects the hypothesis of full insurance at the village level in 30 percent of villages – more so in Khyber Pakhtunkhwa (KP) and Sindh than in Punjab. Informal insurance is less present in villages where incomes are highly correlated, and (surprisingly) where average risk aversion is higher.

Kurosaki and Fafchamps (2002) and Alderman (1996) provide evidence on strategies to mitigate risk and to cope with loss, some of which can be damaging either to farm efficiency or to the household. Kurosaki and Fafchamps use agricultural production and consumption data from the late 1980s on Sheikhupura and find that, despite fairly efficient risk sharing within villages, farmers planted excess fodder to mitigate the risk associated with volatile prices for livestock feed, given the sensitivity of milk returns to fodder price.[6] Risk aversion also led farmers to plant less Basmati rice. The authors measured farmers' risk aversion, finding it to be negatively associated with land and livestock ownership but unrelated (on average) to education.

Alderman (1996) uses the IFPRI dataset to see how savings and consumption behaviors react to shocks in income.[7] One finding is that savings rates are higher in villages where the variability of yields is higher, supporting the hypothesis of precautionary saving. Even when preceded by a positive shock, a negative income shock is associated with increased debt. Moreover, when households face two consecutive negative shocks, they experience a reduction in per capita consumption and proceed to sell their assets.

Foster and Rosenzweig (1996) present a theoretical model supported by simulations of data on rural households in India and Pakistan. They demonstrate that the presence of financial intermediaries (village banks) improves consumption smoothing by increasing the liquidity of assets, which, in turn, enhances commitment to informal insurance arrangements.[8]

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[6] The test for full insurance was that, controlling for village-level consumption, individual household consumption did not vary with individual income.
[7] The districts were Attock and Faisalabad (Punjab), Badin (Sindh), Dir (KP), and Kalat (Balochistan).
[8] The data came from the IFPRI dataset collected in 1986–89 from 52 villages in Punjab, KP, and Sindh.

Murgai et al. (2002) use data on canal water exchange in Punjab to illustrate how the level of informal insurance and size of informal insurance networks depend on the transaction costs associated with forming and enforcing such networks. Given the lack of a constant flow of water through the canal, farmers must trade irrigation time with each other so that they can meet their land's water requirements. The authors suggest that informal insurance may not necessarily take place at the village level or even be restricted to village boundaries but rather within smaller areas (such as a neighborhood) or at least among more homogeneous groups (such as kin). They find that about half the farmers surveyed belonged to a water-trading cluster, with the size of the farm (and, therefore, water variability) determining membership. The size of the water exchange group is positively related to kinship and negatively related to geographical distance.

6. Client Base for Microinsurance in Pakistan

The perceived client base for microinsurance includes the vulnerable (defined as households with an income equal to 100–125 percent of the poverty line) and the quasi-nonpoor (with an income equal to 125–200 percent of the poverty line). Jointly, they make up 80 million people or more than 50 percent of Pakistan's population (SECP, 2012). The SECP argues that those below the poverty line are unlikely to be able to afford insurance, whereas higher-income groups should be able to purchase traditional insurance on their own.

6.1. Current Microinsurance Clients in Pakistan

Aside from the relatively new social insurance schemes initiated by the Pakistan government through the BISP, most microinsurance policies in Pakistan are offered in conjunction with microcredit through MFIs and RSPs. Naya Jeevan—a new insurance intermediary working through corporate value chains (suppliers, distributors, retailers, microretailers)—has also made a small number of HMI policies available.

Since January 2011, the Pakistan government has offered life insurance through BISP, offering household heads premium-free policies of PRs 100,000 (approximately USD 1,000 in 2012 USD). As of 2012, 4.1 million individuals have coverage through this program (BISP, 2012). BISP is also rolling out health insurance: the first pilot has been underway in Faisalabad since April 2012 with plans to expand coverage to five more districts (and up to 1.5 million individuals in all) over the next year or so.

According to numbers provided by the Pakistan Microfinance Network (2012), there were 2.4 million active microfinance borrowers and 2.8 million individuals covered by microinsurance policies served by the microfinance sector as of December 2012. More than half the microinsurance policies held by microcredit clients are credit life policies (1.6 million), which cover the cost of repaying the loan in case of the borrower's death. Most of the remaining microinsurance products offered by the microcredit sector are health insurance policies covering the borrower and in some cases his/her spouse. Insurance policies to cover collateralized assets against which a loan has been taken (e.g., livestock, motorcycles) are available on a limited basis with coverage lasting until the loan has been repaid.[9] The Pakistan Poverty Alleviation Fund (PPAF) is piloting general livestock insurance for small livestock holders.

6.2. Life/Disability Microinsurance

Until 2011, the life microinsurance market was predominately made up by the credit life insurance policies offered (and mostly mandated) by MFIs. The number of credit life policies numbered approximately 1.8 million at the end of the second quarter of 2011. In June 2012, BISP more than doubled the penetration of life microinsurance when 2 million BISP beneficiary households came under life insurance cover. Coverage was expanded to all 4.1 million BISP recipient households as of June 2012. The program intends to have all 7.1 million BISP-eligible households enrolled by 2015.[10]

6.3. Microloan-Associated Life Insurance

Credit life insurance was the first type of microinsurance offered in Pakistan and is typically mandatory for microcredit borrowers. The policy ensures that the outstanding balance of the loan is forgiven in case of the borrower's death. In some instances, such as Kashf, the policy also covers the borrower's "nominee" (loan co-signer), who is typically the household's main breadwinner.[11] The cost of the policy is typically 1–2 percent of the loan amount. Occasionally, the borrower is not charged explicitly for the insurance (Khushhali Bank).[12]

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[9] Tameer Microfinance Bank requires insurance on motorcycles (covering theft and damage) until the loan has been repaid. It is also piloting similar insurance on livestock loans.

[10] Approximately 3 million BISP-eligible households are not yet receiving benefits (cash, insurance, training, etc.) because the household's beneficiary lacks government-issued identification (CNIC).

[11] This has been the case since 2004.

[12] Correspondence with Shahriz Khan (Khushhali Bank).

Microfinance providers mainly offer their credit life policies through private insurers. Jubilee Life Insurance insures a number of microcredit providers—including Kashf, Khushhali Bank, the First MicroFinance Bank (FMFB), and ORIX—covering over 680,000 individuals. In at least one instance (Tameer Microfinance Bank), the organization self-insures its clients, forgiving loans in case of the borrower's death and incorporating the cost into the mark-up on loans.[13]

Critics of credit life policies say that these policies mainly benefit the lender and provide low value for consumers. The experience of Jubilee Life Insurance, however, does not support this. It reports an 84 percent incurred claims ratio (the ratio of payouts to premiums collected) for its business with Kashf's clients in 2012 (see Table 2). Some of the credit life policies that microfinance providers offer in Pakistan do include several of the suggested value-added attributes, such as a payout in addition to loan forgiveness or coverage for additional members of the household.

Table 2: Kashf's credit life experience

From	To	No. of borrowers	Premium	No. of claims	Claim amount	Death claim ratio
1 Jul 2004	30 Jun 2005	5,238	2,560,316	122	2,303,250	90%
1 Jul 2005	30 Jun 2006	31,162	7,930,422	340	6,274,500	79%
1 Jul 2006	30 Jun 2007	76,996	39,075,489	1,198	20,444,053	52%
1 Jul 2007	31 Dec 2007	271,126	31,970,369	1,128	17,991,347	56%
1 Jan 2008	31 Dec 2008	318,957	48,466,862	2,547	40,564,532	84%
1 Jan 2009	31 Dec 2009	64,166	9,924,360	437	7,020,971	71%
1 Jan 2010	31 Dec 2010	108,694	17,249,036	670	12,442,690	72%
1 Jan 2011	31 Dec 2011	109,034	21,988,499	874	17,850,790	81%
			179,165,353		124,892,133	

Source: Authors' correspondence with Kashf.

For example, NRSP's HMI program (offered to its microcredit clients) pays out PRs 15,000 for accidental death/disability of the borrower. Its Urban Poverty Alleviation Program—an urban microcredit program—provides credit life (loan forgiveness) in case the borrower dies, plus 50 percent of the loan value as a death benefit in case of the borrower or spouse's death (NRSP, 2010). Kashf's and Asasah's credit life policies pay out a death benefit of PRs 5,000 in conjunction with its credit life policy, and cover the death of the borrower and spouse. These schemes have low

[13] Tameer was previously working with New Jubilee for credit life insurance.

payouts but also low premiums, which makes them affordable. However, the low level of coverage means that they will not be much more than funeral insurance.

6.4. BISP Life Insurance

BISP provides a fully subsidized life insurance program with coverage that is significant relative to the incomes of the ultra-poor households covered.[14] The insurance pays out PRs 100,000 on the death of the family's adult breadwinner (up to the age of 65 for men or 70 for women). Currently, 78 percent of those insured under the program are male.[15] Claims have been low so far—only about 6,900 out of an anticipated 9,600 as of January 2013 (see Table 3 below for a regional breakdown of coverage and claims in 2011).[16] Consequently, the cost of the program has been significantly lower than expected. Program administrators suspect that current death rates are significantly lower than in the 1998 census from which the premium calculations were made. Other possible reasons include lack of awareness of coverage and the displacement of households due to floods.

Table 3: BISP life insurance coverage and payouts by province/region, 2011

Province/region	Enrollment	Claims paid
Punjab	517,002	2,294
Sindh	725,759	2,306
KP	530,337	1,972
Balochistan	185,964	485
AJK	51,082	414
Gilgit-Baltistan	21,062	319
Total	**2,031,206**	**6,890**

Source: BISP.

[14] BISP intends to capture the ultra-poor. Households with poverty scores lower than 16.17—comprising about 17 percent of the population or 7.1 million households—qualify for program benefits. In comparison, the general poor, according to interviews with BISP, have poverty scores under 32.

[15] While the recipient of BISP's cash transfer program is typically a woman in the household, the choice of the "breadwinner" to be covered by BISP's life insurance policy favors males over females and working members over nonworking members of household. This is aimed at protecting the lives of non-working household members.

[16] Interview with Col. Dr. Javed Abbas (BISP), February 2013.

BISP is working with the State Life Insurance Corporation (SLIC) to manage the funds and administer the life insurance benefits. Instead of paying out premiums for the families covered by BISP life insurance, payouts to beneficiaries are made from a claim reserve fund that is maintained with and invested by SLIC. In addition, BISP compensates SLIC for administrative costs.

6.5. Increasing Value to Life Microinsurance Clients

In the case of credit life insurance, policies could have greater value for clients if they offered the option of higher levels of coverage at higher premiums. In the case of BISP's life insurance, and in the case that credit life policies offer increased coverage, client value could be increased by giving the beneficiary the option of dividing the benefits into multiple payments, to avoid having the windfall spent in the immediate aftermath of the breadwinner's death, either on funeral expenses or captured by relatives. The impact of adding such an option could be studied easily in the context of a randomized control trial (RCT).

7. HMI in Pakistan

While most microfinance providers in Pakistan offer credit life insurance, some have also ventured into the HMI market. The largest players are RSPs such as NRSP and government-funded social protection programs such as BISP. A number of HMI programs have died in infancy, having not made it out of the pilot stage, including the programs introduced by Kashf and FMiA (an offshoot of the Aga Khan Agency for Microfinance). In the first case, utilization was low and clients were provided little value; in the second case, financially viability became an issue. While FMiA is no longer in operation, Jubilee Life has continued to service its clients. There are currently a number of new, comparatively small HMI programs including Naya Jeevan (2011), Pak-Qatar Takaful (2011), Khushhali Bank (2013) and Tameer Microfinance Bank (2010).

HMI is among the most complex insurance instruments to design and implement, particularly because health delivery is a *service* that needs to be provided to individuals, rather than a simple one-time payout, such as in a life insurance or agricultural insurance policy. In addition, for an HMI program to achieve its intended goals, a number of factors must be exactly right (Leatherman, Christensen, & Holtz, 2012). These include:

- The correct design of the HMI product (the amount of coverage and premium, exclusions, cashless reimbursement systems, etc.)

- The quality of the health infrastructure (including hospitals, clinics, and their equipment)
- The quality of the health service delivery (training and incentives of doctors, nurses, and other staff)
- Consumer education (understanding of how to utilize the insurance and what is/is not covered)

Problems along any of these dimensions may cause a well-intentioned HMI program to fail.

7.1. NRSP

NRSP is a private, not-for-profit community organization (CO) that was started with seed money provided by the Government of Pakistan in 1992. Its main work involves organizing rural residents into small COs, whose members are permitted to take out microcredit loans and encouraged to use accrued savings for local development projects (NRSP, 2013b).[17] As of December 2012, there were almost 150,000 COs comprising approximately 2.3 million members divided almost equally between women and men (NRSP, 2013a). There were nearly 380,000 active microcredit borrowers, three quarters of them women (NRSP, 2012). According to MicroWatch, NRSP had issued nearly 750,000 insurance policies as of the fourth quarter in 2012, although these include both health and credit life polices (Pakistan Microfinance Network, n.d.).

NRSP has offered a health insurance scheme in partnership with Adamjee Insurance since 2005. The program has evolved over the last seven years, with incremental changes intended to improve the product's design and cost effectiveness. Initially, the scheme was offered to all members of the NRSP community with an annual premium of PRs 250 for coverage up to PRs 25,000; uptake of the product was voluntary for community members.

However, the organization soon realized that, in order to increase enrollment and reduce the administrative costs of collecting premiums, the HMI scheme had to be linked to its microcredit program. As a result, in 2006 the premium was included in the loan processing and reduced to PRs 100 for health and accidental death/disability coverage of PRs 15,000 for both the borrower and his/her spouse, in effect resulting in an annual premium of

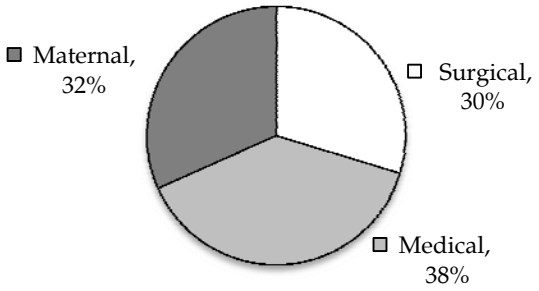
[17] Some microcredit schemes are also offered in urban areas: Islamabad/Rawalpindi, Faisalabad, Multan, and Karachi.

PRs 50 per person.[18] Currently, the annual premium is PRs 100 per person (for all microcredit clients and their spouses), and coverage has been extended to childbirth and an additional benefit for natural death. Currently, 243,337 active loans are covered under NRSP's Microfinance and Enterprise Development Program (covered by HMI) (NRSP, 2013a).

In the initial years of operation, NRSP suffered from a low claims ratio of 23 percent,[19] which it attributed to low product awareness among clients. Product marketing and promotion and customer orientation programs carried out in subsequent years increased the claims ratio consistently to about 60 percent[20] (cumulative) up to 2012. The claims ratio for 2010/11 (alone) was 61 percent. Other key factors that have helped are the inclusion of the spouse in benefit coverage. In 2011, NRSP introduced a cashless system for insurance benefits for some areas at listed panel hospitals. However, if receiving hospitalization at a nonpanel hospital, the client needs to file for reimbursement as before.[21]

Figure 4 shows the different types of claims received by NRSP in 2011/12. As far as coverage is concerned, the insurance scheme excludes pre-existing conditions. The HMI scheme provides coverage for pregnancy and childbirth, and is capped at PRs 10,000. Thirty-two percent of all claims received under NRSP insurance schemes are for maternal health (NRSP, 2012). Since 2011, it has expanded its maternal health insurance coverage to include family planning services as well.[22]

Figure 4: NRSP's breakdown of claims by category



Source: NRSP (2012).

[18] Interview with Jawad Rehmani (NRSP).
[19] Interview with Jawad Rehmani (NRSP).
[20] Interview with Jawad Rehmani (NRSP). The cumulative loss ratio (2006–12) was 74 percent.
[21] Focus group discussions held by the World Bank suggested that clients perceived little value due to the manual reimbursement system: they either lacked the money to obtain treatment or found the system of filing for a reimbursement too difficult (World Bank, 2012).
[22] Interview with Jawad Rehmani (NRSP).

NRSP is in the planning stages of including entire families in its HMI scheme. This product variant is also intended to be a cashless facility covering the entire family, with an expected annual premium of PRs 500–600. The sum insured will also be higher—up to PRs 25,000 per person.[23]

7.2. BISP

BISP is Pakistan's largest social protection scheme to date. The program's cornerstone is a monthly cash grant program that pays PRs 1,000 to extremely poor households in the country. BISP is a targeted program, where households have been identified through a poverty scorecard developed with the World Bank. As of January 2013, BISP had a total of 4.1 million benefit recipient households.[24]

BISP's HMI initiative, Waseelah-e-Sehat, was launched in April 2012 in Faisalabad in collaboration with SLIC. It is still in its pilot phase, and is supported by the Government of Pakistan, which, in turn has received funds from the World Bank and GIZ. In the first year of the pilot, BISP was paying PRs 2,250 per family per annum to SLIC. The program has a unique financing arrangement with SLIC: from the total premiums paid by BISP, SLIC is allowed to keep only 5 percent of the net proceeds after deducting administrative charges (15 percent) and the claims paid. The remaining 95 percent of the profit generated (if any) is transferred back to BISP. What makes this financing arrangement even more interesting is that any loss incurred is borne by SLIC in its entirety.[25] Based on the cost experience so far, BISP has been able to negotiate down the premium to PRs 1,800 for when the program is rolled out in other districts.

The pilot launched in Faisalabad district in 2012 provides in-patient care to all 49,000 cash grant beneficiary households in the district's six *tehsils*. The scheme provides for free hospitalization for up to six members of a beneficiary household for up to PRs 25,000 per beneficiary annually, through eight private panel hospitals. Each of the panel hospitals, chosen through eligibility criteria designed by GIZ, has a BISP helpdesk. While the coverage amount of PRs 25,000 appears small, as of February 2013, only six families in the pilot had exhausted the benefits. To reduce moral hazard,

[23] Interview with Jawad Rehmani (NRSP).
[24] Apart from its basic cash transfer program, BISP has initiated a number of supporting programs for skills development and improving the productivity of the poor, with the intention of helping them "graduate out of poverty." These include Waseelah-e-Rozgar (technical education), Waseelah-e-Sehat (HMI), Waseelah-e-Haq (small business loans for women), and Waseelah-e-Taleem (education).
[25] Interview with Col. Javed Abbas (BISP).

certain procedures such as hospitalized normal and caesarian deliveries have been capped at PRs 5,000 and PRs 7,000, respectively.[26]

BISP's HMI scheme has the advantage of no age exclusions for coverage. However, the plan includes only essential hospitalization, with many important diseases such as cancer, bypass surgeries, and transplants being excluded from the umbrella of coverage. BISP is working to enhance coverage by linking households to the Bait-ul-Maal fund.

BISP's microinsurance includes comprehensive maternity coverage, including hospitalized normal deliveries and caesarians. It is considering offering vouchers for prenatal care and transport[27] as well once the scheme is rolled out to other districts across the country. Early data from the pilot in Faisalabad indicates that the majority of procedures performed on individuals covered by the scheme have been gynecological, highlighting the program's important role in women's health (Table 4).

BISP currently offers a cashless facility to its clients through a "*sehat* (health) card" that allows them to receive medical care at listed private hospitals on the panel. In Faisalabad, where the pilot was initially rolled out, every tehsil has a hospital so that the average distance to any hospital for the client is 5–10 km.[28] However, this is not the case for other districts, where rolling out the pilot will be a challenge because of supply-side issues, specifically the proximity of hospitals.

Table 4: Procedures performed on covered individuals (BISP health insurance pilot 2012)

Type of procedure	Number of procedures
Caesarian	42
Normal delivery (NVD)	41
Hysterectomy	25
Dilation and curettage (D&C)	21
Appendectomy	14
Hernia	12

Source: BISP.

[26] The moral hazard is that medical providers would seek revenues with unnecessary procedures.
[27] The proposed voucher is worth PRs 1,000 for transport for three visits for the family.
[28] This is the average for rural and urban areas; the distance for rural (urban) households is, on average, higher (lower) than this figure.

Hospitalization utilization during the initial phase of the Faisalabad pilot has been low.[29] While some clients complained they had been denied hospital admission by SLIC doctors, the program's administrators have suggested that the low utilization is probably due to the high opportunity cost of availing medical care for the poorest of the poor, many of whom depend on piece rates and daily wages for subsistence.

BISP has contracted with SLIC to expand the HMI scheme in four additional districts: Badin (Sindh), Nowshera (KP), Quetta (Balochistan), Diamir (Gilgit-Baltistan), and Muzaffargarh or Ponch (AJK). Given the lack of private health infrastructure in some areas, BISP is considering empanelling public and military hospitals to ensure access to all insured households. However, one bottleneck is that public hospitals are not currently permitted to retain the generated funds.

7.3. Other Microcredit-Linked HMI Products

Jubilee Life Insurance works with a number of microfinance providers to offer HMI products, including Asasah, the Sindh Agricultural and Forestry Workers Coordinating Organization (SAFWCO), Jinnah Welfare Society (JWS), FMFB, and former FMiA clients. These policies cover hospitalization expenses up to PRs 35,000 per person (for SAFWCO) for the entire family, and PRs 50,000 per person (for Asasah) for the borrower and spouse, at a panel of private hospitals through a cashless system. Asasah charges PRs 650 for the combined health and credit life premium, both mandatory for borrowers. There is no prescreening for insurance coverage, effectively covering pre-existing conditions. Asasah offers maternity benefits only for C-sections. Although exact figures were not made available, Jubilee Life reports that it has experienced losses on its HMI business; the organization currently has around 87,500 HMI clients.

Tameer Microfinance Bank offers a voluntary HMI product in partnership with AsiaCare. The premium amount is PRs 650 per annum per person for coverage of up to PRs 35,000; Tameer does not retain any part of the premium. Initially, the annual coverage was PRs 50,000, which AsiaCare later revised downward to PRs 35,000 per year. The product is only available to Tameer Bank's clients (microsavers, regular borrowers, and even emergency loan borrowers).[30] Other family members are not

[29] Col. Dr. Javed Abbas at BISP estimates that the rate of hospitalization for the poorest households, despite their higher disease burden, is probably about 2 percent; this stands in comparison to 3.5–4 percent for the Pakistani population overall.

[30] Interview with Kashif Ahmed and Usman Malik (Tameer Microfinance Bank).

eligible. The product covers hospitalization only, but does not include essential medical services for women such as hospitalized normal deliveries and caesarians. Pre-existing conditions are covered but after 45 days of taking up the policy. The ratio of men to women covered under HMI by Tameer is 60:40. About 19,000 health policies were sold in 2012.

Khushhali Bank launched its first HMI scheme in March 2013, also in partnership with AsiaCare. The annual premium is PRs 750 for Rs 35,000 coverage. The policy covers hospitalization, surgery, and cancer treatments, but excludes maternity care.

7.4. Kashf's HMI Experience

In November 2007, Kashf initiated a six-month HMI pilot for clients and their nominees of three Lahore branches. During the pilot, uptake of the HMI product was mandatory for new or repeat microcredit borrowers, leading some clients to switch branches. The premium was PRs 700 for PRs 25,000 coverage for a one-year period for the borrower and her nominee, in most instances a spouse, father, or brother. Pre-existing conditions were covered at 50 percent for the first three months of the policy. Borrowers were hesitant (but required) to purchase the policy as an upfront payment associated with the disbursement of the loan; some were able to halve the premium to be paid by claiming that their spouse did not live with them (Khan, 2008).

The program suffered from low recognized value among its clients. According to 10,590 clients who received coverage under the pilot, 31 out of 34 claims were paid out by September 2008 (Kashf Foundation, 2008). PRs 3.7 million was collected in premiums, but only PRs 0.39 million was paid out (out of initial claims of about PRs 0.53 million) for a payout/premium ratio of only 10.5 percent. Despite focus groups of clients pointing out that pregnancy complications/caesarians were among the most expensive medical conditions they might have to deal with, the pilot policies did not cover costs related to childbirth (normal or caesarian) or many other gynecological problems (other than malignancies, ectopic pregnancy, miscarriage, and preeclampsia). Clients were not well informed about the limitations and exclusions of their policy, and were disappointed when they were told that their costs would not be covered (Khan, 2008).

The system was cashless for only some of the panel hospitals, and for those operating through reimbursement, claims took two to four months to process. The biggest problem in terms of client value, however, was probably that the majority of the panel hospitals were public

facilities.[31] Public hospitals already provide doctors' services free of charge, so the insurance was only covering diagnostic charges, lab tests, medication, and operating room and ICU charges. Clients complained of poor service and being turned away for lack of beds (Khan, 2008). They were also reluctant to visit the military hospital on the panel and confused that they were authorized to obtain treatment there (Khan, 2008).

Kashf plans to initiate a new HMI pilot that will expand coverage to children and include pregnancy-related costs.[32] Jubilee Life Insurance has estimated that, for PRs 25,000 coverage, the premium will be around PRs 1,100 per household. Kashf has a large number of clients—currently about 200,000—and enough to gain negotiation leverage with insurance companies. It has also started working with UBL Omni and Telenor Easypaisa to make mobile phone-enabled deposits and loan payments. These mobile technology platforms could also be used to spread out payments on HMI policies.

7.5. HMI Outside the Microcredit Sector

Naya Jeevan, a not-for-profit social enterprise founded in 2007, began offering HMI in 2011. It follows a unique HMI model for providing low-income families and the working poor access to quality healthcare. An estimated population of 76 million in Pakistan is formally or informally connected to the supply chains of major corporations, whom Naya Jeevan aims to insure: these include suppliers (farmers, agribusiness, raw material providers), logistics companies (distributors), and vendors (wholesalers, retailers, and microretailers) (Naya Jeevan, 2012).

Naya Jeevan hopes that major corporations wishing to improve their image with respect to corporate social responsibility may be willing to co-finance the insurance of these low-income staff and contractors at lower levels of coverage and premiums compared to the plans offered to management-level corporate employees. It intends for the majority of insurance premium contributions to be made by the primary employer (80 percent) and the remainder made by the beneficiary (10 percent) and the employer's employer/contractor/sponsor (10 percent).

Currently, Naya Jeevan offers two variants of the health insurance product. The first is an HMI product for low-income employees in the

[31] The original panel hospitals were: Lahore General (public), Ittefaq Trust (private), and the Combined Military Hospital (military). Later added were the Services Hospital (public), Sir Ganga Ram (public), the Punjab Institute of Cardiology (public), Mayo Hospital (public), and Fatima Memorial.
[32] Interview with Maham Tarar (Kashf Foundation).

formal and informal sectors with a maximum income of PRs 15,000–25,000 per household, for coverage up to PRs 200,000.[33] The organization approaches employers in the formal sector (e.g., Unilever) as well as employers of domestic staff (drivers, housemaids, cooks, etc.) to fund the insurance premiums for their employees. The second product variant, currently in the pilot phase, follows the self-insurance model: instead of transferring the risk to the employer, low-income individuals pay for HMI themselves via a community-based risk-pooling platform.

The two products are also priced differently: the former costs PRs 200 per worker per month, while the latter is a self-pay option priced at PRs 150 per individual per month (or PRs 5 per day auto-debited from their mobile phone). The difference in price is to account for an adverse selection bias as employers may have a greater propensity to enroll their least healthy employees in an HMI plan. Coverage is up to PRs 150,000 per person per year. For every dollar of incoming insurance contribution (revenue), 60–80 cents are used to buy health plans from insurance underwriters (suppliers). The remainder is used to cover additional client services, mostly 24/7 telephone access to a team of family medical doctors, discounted access to outpatient services, annual health risk assessments, group orientation for beneficiaries, and preventive health education.

Naya Jeevan's HMI model consists of a *core health plan* that covers inpatient expenses for hospitalization in addition to outpatient services needed 20 days prior to and post-hospitalization. In addition, a team of six in-house doctors navigates members through the various steps of the medical treatment process via a network of 190 private hospitals nationwide. For corporate groups, the organization offers coverage of pre-existing conditions for enrolling a group larger than 200 clients.[34] Naya Jeevan also offers a comprehensive pregnancy and childbirth plan for clients covering prenatal and postnatal care for both natural births and surgeries at an additional PRs 50 per month, subject to a 10-month waiting period.

As of June 2013, about 24,000 beneficiaries are part of the employer-funded healthcare plan enrolled across more than 100 organizations, including Unilever, Sanofi, Philips Electronics, Pakistan International Container Terminal, and Jafferjees. Currently, 80 percent of the beneficiaries are concentrated in urban centers in Sindh, particularly Karachi.

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[33] In some cases, the income cap for eligibility for HMI by Naya Jeevan is raised to PRs 25,000 per month. This may be at the employer's discretion or because there is more than one earning member in the family. Typically, its clients consist of blue-collar workers.

[34] For domestic workers in the informal sector, Naya Jeevan makes its own pool and effectively provides coverage for pre-existing conditions.

The self-insurance model is being piloted in Sultanabad—an urban slum in Karachi where a subset of 25,000 beneficiaries was randomly selected from a population of about 250,000. Out of this subset of 25,000, 5,000 beneficiaries have been enrolled in the comprehensive healthcare plan, which is initially free of charge (funded by USAID). The remaining 20,000 have access to all the value-added services in the form of a preventive healthcare plan. The aim of the pilot is to measure the impact of HMI and assess whether exposure to the product enhances its uptake and the perceived value of HMI for the population.

In the coming year, Naya Jeevan hopes to pair up with a major telecom provider in Pakistan and start offering its healthcare products to low-income clients via mobile phone-enabled enrolment. It also plans to expand its current network of about 30 primary care partners nationwide and conduct health assessment examinations to extend coverage to areas outside urban Sindh.

Naya Jeevan's business model is innovative and has drawn international attention and donations, but whether the model is financially sustainable and scalable remains to be seen. The cost of the insurance, at PRs 1,800–2,400 per person per annum is significantly higher than that of all other HMI plans in Pakistan. According to its CEO and founder, Dr Asher Hasan, the organization aims to achieve financial sustainability by 2015 if it can reach a client base of 150,000. As with other forms of microinsurance, there have been limited assessments of the impact of such programs. Naya Jeevan is partnering with international academics to measure the impact of the Sultanabad pilot.

7.6. FMiA's Experience in the Northern Areas

The Aga Khan Agency for Development created FMiA in 2007 to provide HMI to clients in Hunza, Gilgit, and Ghizar in the Northern Areas. The policy was comprehensive, offering PRs 25,000 coverage per family *member* per year; one yearly doctor's visit for each family member; inpatient maternity, prenatal, and postnatal care (from 2009 onward); and a PRs 25,000 life insurance policy for one breadwinner (McGuinness & Mandel, 2010). The annual cost of the policy was PRs 400 per person. The system was cashless for military and Aga Khan network facilities. The insurance was offered by Jubilee Life, which is also owned by the Aga Khan Development Network.

The policies were marketed through local service organizations, village organizations, and women's organizations. At least 50 percent of

the members of the local village organizations or women's organizations concerned (organized by the Aga Khan Rural Support Program) were also required to sign up to reduce adverse selection. By December 2008, despite a short enrollment period, more than 19,000 individuals had enrolled in the HMI program (McGuinness & Mandel, 2010).

Due to its inability to become financially sustainable, FMiA closed down its operations in 2011 but Jubilee Life Insurance still offers HMI in these areas in partnership with COs. Since November 2011, it has changed the premium to a family-level rather than a per-person premium. The premium is PRs 2,000–2,300 for a family of five and PRs 300 for additional members.[35]

7.7. HMI: Discussion

HMI policies in Pakistan tend to focus on catastrophic events such as hospitalization, and typically exclude chronic illness and outpatient visits. Given that microinsurance does not screen applicants, this is necessary to avoid adverse selection where only the sick enroll. Some policies cover women's issues including caesarian deliveries, but many do not. For the policies that do include women's reproductive health, these make up a large share of the claims (NRSP, BISP). This highlights the need to include such cover, but premiums also need to be high enough to ensure financial sustainability.

In order to discourage doctors from converting normal deliveries into caesarian procedures, both BISP and NRSP have caps on coverage (PRs 7,000–10,000) so that the patient has to cover at least half the cost. Some programs cover cancer treatments, but not all. Programs that function by reimbursement tend to have low claims ratios and, therefore, lower client satisfaction and value (Kashf's pilot, NRSP) (Khan, 2008; World Bank, 2012). NRSP is moving toward a cashless system (in Punjab, and soon in Sindh).[36] In rural areas, transportation to health facilities is an important issue (SECP, 2012; McGuinness & Mandel, 2010) that could be covered by vouchers. NRSP's microinsurance is one of the few that does cover transportation costs.

Clients' feedback suggests that they do not experience high levels of satisfaction from policies when they do not submit any claim, and sometimes expect that at least part of the premium should be returned or a

[35] Interview with Malik Khoja (New Jubilee).
[36] Interview with Jawad Rehmani (NRSP).

discount for the following year applied in case a claim is not filed (McGuinness & Tounytsky, 2006, for Pakistan; Platteau & Ontiveros, 2013, for India). An option potentially worth exploring is a combination of health savings accounts (HSAs) and catastrophic insurance coverage.

It is true that HSAs have been attempted in a limited number of countries, including Singapore, China, South Africa, and the US, with effects that have generally been less than positive for consumers. These have included cost shifting from the government to patients (Singapore and China) or reductions in benefits as in South Africa (Thomson & Mossialos, 2008). In the US, the uptake of HSAs along with high-deductible plans has been low, along with customer satisfaction, compared to traditional insurance (Glied, 2008). In these contexts, HSAs were set up to reduce healthcare expenditures on the premise that moral hazard leads traditionally insured individuals to overuse healthcare.

In Pakistan, on the other hand, most people have had no exposure to traditional health insurance (covering routine care and outpatient services) nor is it available to the majority of the population, given the prohibitive cost and adverse selection concerns. The HMI plans currently offered in Pakistan are akin to the "catastrophic coverage" policies in the US, and mainly cover hospitalization while limiting or excluding coverage of outpatient visits, outpatient medication, maternity services, and chronic or pre-existing conditions. As a result of these limitations, the utilization of covered services tends to be low and the insured may feel that they should be reimbursed at least part of their premium.

One proposal for a combined HMI and HSA plan is as follows: a family could contribute between PRs 200 and PRs 300 a month, where PRs 100–150 per month would go toward HMI (i.e., a PRs 1,200–1,800 family per annum premium) and the remainder would go toward an HSA. The HMI would provide catastrophic coverage for hospitalization, surgery, and some chronic conditions, while the HSA could be used to pay for outpatient visits and medication.

If health savings accumulate, monthly contributions could go down and if HSAs fall below a certain threshold, the required monthly contributions would go up. Clients will have the satisfaction of feeling that they are gaining some tangible benefits from the monthly contributions they make, and will have to pay less when they do not use medical services. A recent RCT in Kenya found that informal HSAs had over a 90 percent take-up rate and allowed households to accumulate savings that were later used to cover medical emergencies (Dupas & Robinson, 2013).

8. Other Insurance Providers: Pakistan Postal Insurance and Mobile Microinsurance

8.1. Pakistan Postal Insurance

The Pakistan Post Office offers a variety of insurance policies, some of which—given the range of options for coverage (starting at PRs 50,000 and up to PRs 5 million)—could be considered microinsurance. A wide variety of options are available to suit the individual needs of families, including whole-life policies (payout at age 85 or at time of death), endowment policies (paid at expiration of term or at death), joint-life policies (two persons insured), three-payment plans (share of payout disbursed at three points in time during term of policy), education and marriage endowments (paid after 5–17 years or at death), disability insurance, child protection (one child aged 1–17 and one parent insured), and group insurance. The number and characteristics of people currently insured is not known, but there were 252,810 policies in effect in 2004 (Nenova et al., 2009).

8.2. Mobile Microinsurance

Branchless banking in Pakistan, introduced in 2008, has recorded consistent growth by leveraging the mobile technology network. The total number of branchless banking accounts had increased to more than 1,815,611 and total deposits were valued at PRs 839 million as of September 2012 (State Bank of Pakistan, 2012). This growth has been led by two main products: Telenor Easypaisa and UBL Omni.

The substantial penetration of mobile phones in Pakistan is seen as a way to increase the microinsured, by means of telecom companies (SECP, 2012). Mobile subscription in Pakistan had already reached 114 million users in December 2011, meaning that about 60 percent of the population had access to a mobile phone (Pakistan Microfinance Network, 2012). With a number of microfinance providers already using branchless banking, there is an opportunity to use the same methods to enroll and receive payments for microinsurance (Pakistan Microfinance Network, 2012).[37]

Some life insurance policies already operate this way, collecting payments by means of the telecom companies on a weekly or even daily basis (SECP, 2012). These include Easypaisa and Zong, which both work with Adamjee Life. They are simple to administer (clients sign up by phone

[37] Asasah and SAFWCO allow borrowers to use Easypaisa for disbursement and repayment; the Thardeep Rural Development Program, Rural Community Development Society, JWS, and Kashf use Omni for repayment only (Pakistan Microfinance Network, 2012).

call or text message) and premiums do not have to be paid as a lump sum—both characteristics that make them easy to afford for lower-income segments and compatible with established microinsurance models.

Easypaisa (a project of Tameer Microfinance Bank, in partnership with Telenor) launched Easypaisa Khushaal in 2012, under which complimentary life insurance is given to customers who maintain a minimum balance in their mobile accounts and sign up for the service (Easypaisa, 2013). The amount of coverage depends on the balance maintained (see Table 5). While there is no explicit insurance premium, the insurance coverage is not "free" in the sense that Easypaisa balances do not earn any interest, so that holding large sums in the account presents an opportunity cost.

Table 5: Minimum balances and insurance benefits from Easypaisa (PRs)

Easypaisa balance	Benefit (natural death)	Benefit (accidental death)	Additional monthly benefit for balances > PRs 25,000
2,000–5,000	50,000	100,000	
5,001–10,000	100,000	200,000	
10,001–25,000	250,000	500,000	
> 25,000	500,000	1,000,000	5,000 per month for 5 years

Source: Easypaisa (2013).

Zong has offered accidental death and disability insurance since 2011, with premiums deducted daily from the client's mobile phone balance (Zong, 2013). The rates and level of coverage are given in Table 6.

Table 6: Zong accidental death and disability insurance: Coverage and rates (PRs)

Plan	Accidental death/ accidental disability benefit	Funeral expense benefit in case of accidental death	Daily user charges	Daily deduction from mobile balance (with taxes)
1	100,000	5,000	2	2.10
2	200,000	5,000	4	4.27
3	300,000	5,000	5	5.29

Source: Zong (2013).

9. Impacts of Microinsurance

Scientific evaluation of microinsurance through an RCT requires the participation of an evaluation team before any new insurance product

is marketed, and preferably during the design phase of the product. An RCT requires collecting baseline information on the target population, and then marketing and/or subsidizing the product for a random sample of the target population so that the "treatment" effect can be measured against the "control" group to eliminate the bias of self-selection into the program. There has only been one completed impact evaluation of microinsurance in Pakistan using the RCT method (Landmann & Froelich, 2013), and one ongoing experiment (Naya Jeevan).

Landmann and Froelich (2013) find a reduction in child labor incidence (especially in hazardous occupations) and fewer missed schooldays (particularly for boys) among families near selected branches in Hyderabad where NRSP had, on a pilot basis, allowed additional family members to enroll in its HMI scheme.

10. Scaling up Microinsurance

In the short to medium term, life microinsurance could be scaled up by covering spouses and offering supplemental higher levels of coverage. Focus group discussions held by the World Bank (2007) and Microfinance Opportunities (McGuinness & Tounytsky, 2006) suggest that clients gain value from SLIC's regular education endowment and life policies, which pay a lump sum after a term of 15–20 years or on the death of the insured. These policies combine commitment savings with life insurance. Linking branchless banking with microfinance providers to offer insurance products and lower the transaction costs incurred by SLIC and Pakistan Postal Insurance may unleash demand.

HMI could be scaled up in the short to medium term by covering microfinance customers' entire families. Currently, NRSP's HMI scheme covers only borrowers and their spouses, but if plans go through to offer a family plan, coverage would increase significantly. Enrolling the families of its 2.3 million CO members—rather than just the 200,000–250,000 rural borrowers and their spouses—would also provide a significant boost. Although NRSP had marketed its HMI plan to the COs when it started, it found the administrative costs of collecting the premiums prohibitive. In this context, payment through mobile accounts could reduce transaction costs. Another way of scaling up microinsurance would be for the provinces to offer insurance to poor households who just miss the BISP cut-off; the poverty scorecard data is already available and this would considerably improve the reach of the social safety net.

With HMI, the problems associated with adverse selection (that only the sick are willing to purchase insurance) could be mitigated through mandatory enrollment. If HMI is voluntary, one option would be to require that a certain percentage of the community signs up for the group to qualify. FMiA attempted this with mixed results, so it is not a guarantee that the product would be sustainable.

11. Conclusions

When microinsurance is voluntary, take-up rates are low and renewal rates even lower. A survey of eight index and health insurance programs in developing countries had take-up rates of 6 to 36 percent, with many in the teens (Churchill & McCord, 2013). While there is some correlation between financial literacy and insurance ownership, the study found that educating individuals about insurance had some impact on the take-up of index insurance but no effect with respect to health insurance.

In the US, nearly all (97 percent) of the 61 percent of workers offered life insurance by their employers take it up (US Bureau of Labor Statistics, 2012). Therefore, life insurance as an employment benefit may be a way to increase the number of formal sector employees insured. Of course, those employed in the formal sector in Pakistan already have access to the Employees Old-Age Benefits Institution (EOBI), which makes disability payments to injured workers and also pays survivor benefits. Families of active-duty military personnel also have access to low-cost or free healthcare.

On the other hand, people do not always purchase the level of insurance they need, nor do they necessarily take up free insurance, even in developed countries. One study has shown that at least a third of near-retirement households in the US were underinsured and would experience a significant reduction in their standard of living if the breadwinner passed away (Bernheim, Forni, Gokhale, & Kotlikoff, 1999). In the US, two thirds of Medicaid-eligible children are uninsured (Baicker, Congdon, & Mullainathan, 2012);[38] 25 percent of individuals without health insurance were offered subsidized plans through their employers but opted out (Baicker et al., 2012).

In some cases, affordability and screening by insurance companies may have been an issue, but not all; 20 percent of the uninsured have household incomes of USD 75,000 or more. One study has estimated that between 25 and 75 percent of the uninsured in the US can afford health

[38] Medicaid is the US government's free health insurance program for low-income individuals.

insurance but have opted out (see Baicker et al., 2012). Outcomes for the uninsured are often worse than for the insured, as shown by an RCT on the impact Medicaid. The study also suggests behavioral/psychological reasons for the large number of uninsured, including the complexity of the choice, (mis)perceptions of risk, present bias, context, and framing.

Some of these behavioral/psychological reasons were offered and tested on a population in India where the uptake of HMI was very low. Ito and Kono (2010) have found evidence of the effects of both prospect theory (where individuals are risk-loving with respect to losses, leading to underinsurance) and hyperbolic discounting (present bias).

These figures lower hopes that insurance penetration can reach high levels in developing countries where financial literacy is low. McGuinness and Mandel (2010) find that only 13 percent of families subscribed to FMiA's HMI program. NRSP has had to link HMI to its lending operations to build up its numbers and lower the cost of collecting premiums. Tameer's health insurance program is new, but comprises only 19,000 clients out of nearly 155,000 active borrowers. Kashf's clients complained about the mandatory nature of the HMI pilot.

As for achieving premium prices that will offer good value to microinsurance clients, BISP's experience in developing its health insurance component and negotiating with insurance companies (eventually opting for a state-owned insurer) for a large group of clients offers some important insights. The private insurance market is thin, and when BISP put out an expression of interest to the insurance industry, eight companies put in bids, out of which only four companies qualified under the World Bank's criteria.

At least one company has suggested that it would be willing to insure under a system of reimbursement rather than the cashless system that BISP advocated. Private companies, stating that insuring the ultra-poor is very risky, formed a consortium and proposed charging a premium three to four times what BISP is currently paying SLIC.[39] Such a high proposed premium may have resulted from lack of information about the risk to be insured and/or a thin insurance market. As a result, SLIC, which was previously mandated to offer only life insurance, has now received the mandate and statutory government funding needed to offer BISP's HMI.

[39] Interview with Col. Dr Javed Abbas (BISP).

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Annex

Life microinsurance in Pakistan

Microcredit provider	Details
Kashf Foundation	Credit life offered; mandatory for microcredit customers. Premium is 2 percent of the loan amount for a loan up to PRs 20,000 and 1 percent of the remaining loan amount. Premium covers both the microcredit client and her nominee (husband or other male breadwinner of the family). In addition, funeral charges of PRs 5,000 are paid (correspondence with Kashf).
Khushhali Bank	Credit life insurance for borrowers, covering death/disability of borrower. Sum insured is the outstanding loan amount. Premium built-in loan processing. Covers borrower only and only loan amount. No funeral charges paid.
NRSP	Credit life offered for urban clients. In case of death, the outstanding loan balance and interest is paid, and 50 percent of the loan amount disbursed is paid to the borrower's heir/family to cover funeral expenses (NRSP, 2012).
Tameer Bank	Credit life offered. If a person dies, the loan is waived, in addition to a funeral charge of PRs 5,000. Life insurance is mandatory for all microcredit clients and is built into the markup for microcredit that the bank is already charging them (correspondence with Tameer Bank).
FMFB	Credit life offered. Premium is linked to loan amount: PRs 50–350 for loan amount of PRs 5,000–150,000. Covers only borrower. Linked to loan duration. Separate premium for death benefits insurance: funeral charges PRs 10,000 (normal death), PRs 20,000 in case of accidental death (correspondence with FMFB).
Akhuwat	Islamic microcredit institution. Offers micro-*takaful* (Islamic credit life). PRs 100 is paid toward premium for life insurance. In case of death, loan balance is waived. Funeral charges of PRs 5,000 are also paid. This product is mandatory for all microcredit borrowers (correspondence with Akhuwat).
Asasah	A total premium amount of PRs 650 is charged, which covers both life and health insurance. In case of death of borrower, up to PRs 50,000 of the outstanding loan amount is waived and PRs 50,000 is paid in funeral charges (correspondence with Asasah).
PRSP	Life insurance (death, accidental death, and disability offered in partnership with SLIC).

Microcredit provider	Details
BISP	Group life insurance (GLI). Under this scheme, insurance cover of PRs 100,000 is paid out on the death of the male breadwinner of the family. The insurance is underwritten by the state-owned SLIC and BISP pays SLIC the premium on behalf of poor households. In the first phase, 2 million poor households already receiving BISP cash grants were provided with GLI. Coverage has subsequently been extended to all 4.1 million cash grant beneficiary households as of June 2012, and the scheme been made compulsory for all cash grant beneficiary households (correspondence with BISP).
Pak-Oman Microfinance Bank	Offers credit life insurance in partnership with ALICO/AIG insurance.
Daamen	Credit life. Premium is 3 percent of the loan and covers the outstanding loan amount along with PRs 7,000 in funeral charges in case of death of borrower (correspondence with Daamen).
SAFCO Support Foundation (formerly SAFWCO)	Credit life, which provides coverage to client's family if the client dies during the period of repayment (one year or six months as per agreement). Premium is 1 percent of loan amount. In case of client's death, the entire remaining amount is waived. The entire amount deposited with the organization (except service charges) is returned to the client's family members/nominee.

HMI Initiatives in Pakistan

Discontinued programs

HMI provider	Program duration	Details
Kashf Foundation	2007–08	Pilot health insurance product launched in 2007. Premium was PRs 350 per person for coverage amount. The product was mandatory for all clients who had taken a loan from pilot branches.
FMiA	2007–11	Premium charged depended on location and partner organization. In Gilgit-Baltistan, it started at PRs 350 per person per year for coverage of PRs 25,000 in 2007. FMiA closed down due to sustainability issues but Jubilee Life still offers health insurance in these areas in partnership with COs.

Ongoing programs

HMI provider	Started	Details
Tameer/AsiaCare	2010	HMI product offered in partnership with AsiaCare. Premium amount is PRs 650 per annum per person for coverage up to PRs 35,000. Coverage is only for the individual and does not include spouse or other family members. About 19,000 health policies were disbursed in 2012.
Naya Jeevan/Saudi Pak, Pak Qatar, Allianz-EFU, IGI, Warid Telecom	2010	Two products: (i) Employer co-financed health insurance product for low-income employees in the formal and informal sectors with a maximum monthly income of PRs 20,000. Premium is paid by the employer and amounts to PRs 200 per worker per month for a coverage amount of PRs 150,000. The program has about 24,000 beneficiaries enrolled as of June 2013. (ii) Self-insurance product (in pilot stage with a treatment group of 5,000 people) offered directly for uptake by low-income individuals where they pay their own premium of PRs 150 per person per month or PRs 5/day. Naya Jeevan plans to offer health insurance through a mobile network in partnership with Warid Telecom.
Asasah/Jubilee Life	2011	HMI is mandatory for all microcredit clients. Premium is PRs 650 per annum for coverage up to PRs 50,000 each for borrower and spouse. Coverage only includes hospitalization. Part of the same premium is paid toward credit life insurance, which is also mandatory for Asasah's clients. Hospitalized normal deliveries are not included, but other contingencies such as caesarians and hysterectomy are covered. The cumulative number of individuals insured from January 2011 to December 2012 is 14,121. Total number of active policyholders is 5,584.
BISP/State Life Insurance	2012	Pilot with 50,000 families started in April 2012. Premium of PRs 2,250 per annum per family for coverage up to PRs 25,000 for all family members. Premium is paid by the Government of Pakistan for families selected through the poverty scorecard.
Pak-Qatar Takaful	2011	?

HMI provider	Started	Details
Zong/Adamjee Life	2012	Insurance for accidental death or disability caused by an accident or terrorism. Daily premium varies between PRs 2 and 5 (USD 0.2–0.5) for annual cover of PRs 100,000–300,000.
PPAF and partner organizations: PPAF/SAFWCO PPAF/JWS PPAF/BRAC PPAF/RCDS	2011	PPAF has run various pilot projects with its partner organizations: with JWS in Gujranwala and Hafizabad, RCDS in Sheikhupura and Nankana Sahib, and SAFWCO. A total of 13,000 individuals covered in one year. PPAF has also carried out a pilot in collaboration with BRAC for district Lasbela in Balochistan, covering 15,000 individuals. The results of these pilots are mixed. The policies dispersed by JWS, for example, did not yield satisfactory results and suffered from low claims ratios. Certain partners have continued with the policies after the pilots ended (PPAF, 2012).
FMFB	2009	FMFB started offering HMI in partnership with Jubilee Life in Karachi and northern Punjab. Premium varies according to the geographical region: PRs 800 per annum per family in Karachi and PRs 950–1,000 in northern Punjab. Coverage amount is PRs 50,000 per household for hospitalization only. The entire family is covered except the borrower's parents. Hospitalized normal deliveries are not covered. Pre-existing conditions are covered 50 percent for first three months and 100 percent thereafter. Health insurance is mandatory for all FMFB's microfinance clients.

HMI provider	Started	Details
Rural Support Program Network (RSPN)/Adamjee	2005	First HMI scheme in Pakistan, providing hospitalization and accident insurance coverage to low-income rural population across the country. There are 10 RSPs in Pakistan under the RSPN umbrella, of which six offer HMI. Health insurance covers hospitalization costs, accidental injuries, disability compensation, and compensation in case of accidental death. Annual premium set at PRs 250. Limits per insured person are PRs 25,000 (for hospitalization) and PRs 25,000 (for accidental death) for a total of PRs 50,000. Coverage includes all associated procedures relating to pregnancy and also vouchers for transportation. The total cumulative number of policyholders was 3,380,609 as of June 2012, of which 914,377 are men and 2,466,232 are women (*RSPN Outreach*, issue 14).
NRSP		Largest provider of HMI in Pakistan, accounting for about 50 percent of all health policyholders. Premium amount is a total of PRs 100 per annum for both borrower and spouse. Coverage includes only inpatient hospitalization due to illness and accidental death or permanent disability resulting from accidental bodily injury with a limit of PRs 15,000. Cumulative number of policyholders up to June 2012 was 2,379,905.
Aga Khan Rural Support Program		Cumulative number of policyholders for HMI was 621,184 as of the second quarter of 2012 (*RSPN Outreach*, issue 14).
Sarhad Rural Support Program		Aims to provide free health insurance to 32,000 families under the microhealth program component of the Bacha Khan Poverty Alleviation Project in eight union councils in Upper Dir. The cumulative number of HMI policyholders was 27,400 as of the second quarter of 2012.
Sindh Rural Support Organization		Cumulative number of HMI policyholders was 204,696 as of the second quarter of 2012.
Thardeep Rural Development Program		Cumulative number of HMI policyholders was 127,409 as of the second quarter of 2012.
Ghazi Barotha Taraqiati Idara		Cumulative number of HMI policy holders was 20,075 as of the second quarter of 2012.

Future programs

HMI provider	Expected start date	Details
Kashf Foundation	2013	Product in design stage.
Khushhali Bank	March 2013	Plans to offer Sehat Khushali—an HMI product to be launched in March 2013 in partnership with AsiaCare. The pilot will be launched in six different cities (Hyderabad, Sukkur, Rahimyar Khan, Lahore, Okara, and Mardan) for two months, after which the product will be rolled out on a commercial basis in other districts. Premium amount is set at PRs 750 per person annually for coverage amount up to PRs 35,000 for hospitalization only in AsiaCare's panel hospitals. If treatment is availed at a nonpanel hospital, only 60 percent of the incurred expenses will be reimbursed by AsiaCare.
NRSP/Adamjee family coverage		NRSP is currently involved with Adamjee Insurance in designing a pilot project that will cover clients' entire families in an HMI scheme. This product variant is also intended to be a cashless facility covering the entire family, with an expected premium of PRs 500–600 per annum. The sum insured will also be higher: up to PRs 25,000 per family member.
Daamen	June 2013	Daamen is currently in discussion with Adamjee Insurance to launch an HMI product. Premium is expected to be PRs 200 for hospitalization coverage for the entire loan tenure (12 months). The premium covers both borrower and spouse for hospitalization expenses up to PRs 25,000. Reproductive services such as hospitalized normal deliveries and caesarians not covered.